STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155426	A. BUILDING _____ B. WING _____	C 10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL OAKS HEALTH CARE AND REHABILITATION CENTER	3500 MAPLE AVE TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for an Investigation of Complaints IN00097040 and IN00097411. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure completed on 8/30/11. Complaint Number IN00097040- Unsubstantiated/due to lack of evidence. Complaint Number IN00097411- Substantiated/No deficiencies cited. Survey Dates: October 4 & 5, 2011 Facility Number: 000513 Provider Number: 155426 AIM Number: 100275360 Survey Team: Mary Weyls, RN-TC Laura Brashear, RN Debra Skinner ,RN Teresa Buske, RN Census Bed Type: SNF/NF: 179 Total: 179 Census Payor Type: Medicare: 26 Medicaid: 124 Other: 29 Total: 179 Sample: 7 Royal Oaks Health Care and Rehabilitation	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00097040 and IN00097411. Quality review completed on October 7, 2011 by Bev Faulkner, RN	F 000		